MEDICAID CBH POLICY OVERVIEW

JANUARY 5, 2022

AGENDA

- Acronyms
- Medicaid Basics
- Historical Perspective
- Rule 140
- Overview of the changes to Rule 132/Rule 140
- Audit and Record Requirement Basics
- Key Players and their Role in the Medicaid CBH System
- Resources

ACRONYMS

BALC	Bureau of Accreditation, Licensure and Certification
BHC	Behavioral Health Clinic
CBH	Community-based behavioral health
CMHC	Community Mental Health Center
DCFS	Department of Children and Family Services
DHS-DMH	Department of Human Services, Division of Mental Health
FFS	Fee for service
HFS	Department of Healthcare and Family Services
IMPACT	Illinois Medicaid Provider Advanced Cloud Technology
IATP	Integrated Assessment and Treatment Plan
IP	Independent Practitioner
IPI	Infant Parent Institute
MCO	Managed Care Organization
OMI	Office of Medicaid Innovation
PPR	Post payment review
SASS	Screening, Assessment and Support Services
TPL	Third Party Liability

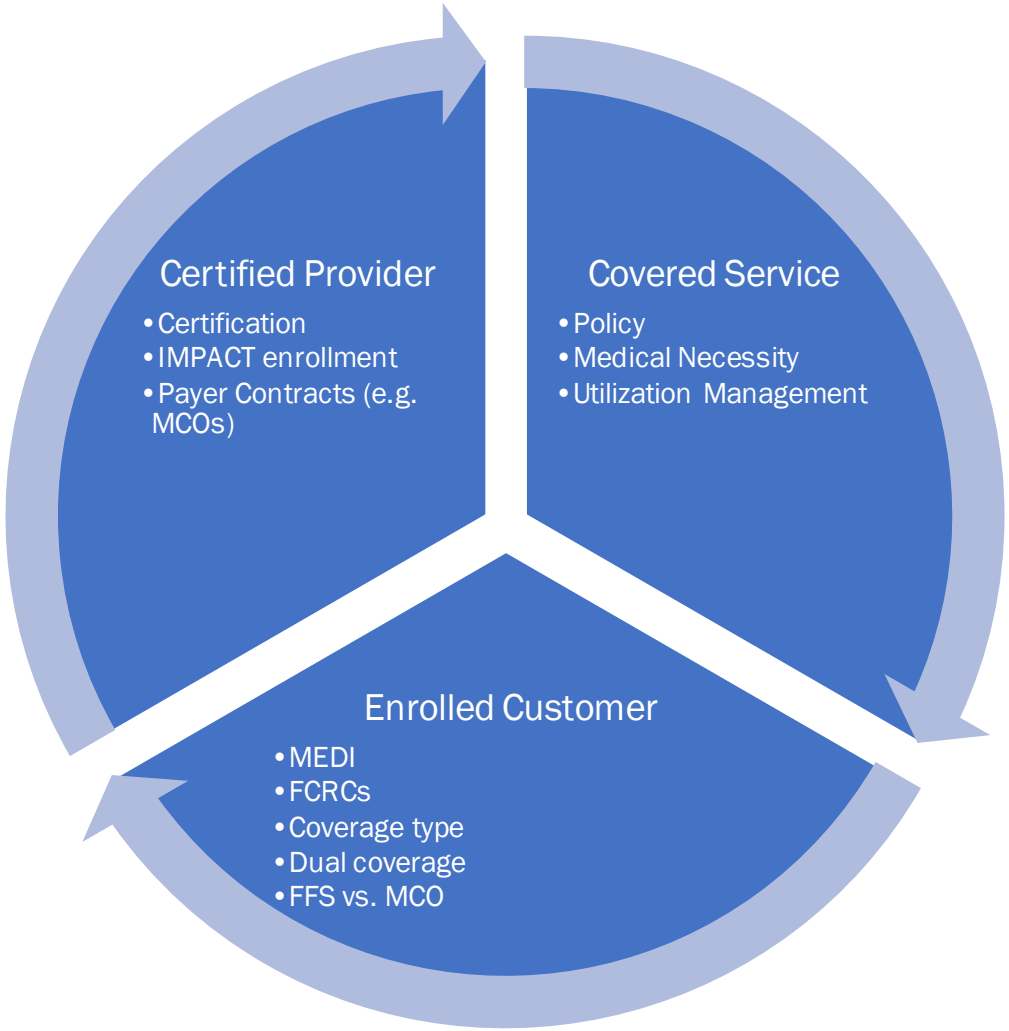
A FEW MEDICAID BASICS

For Medicaid to pay a claim, there must be:

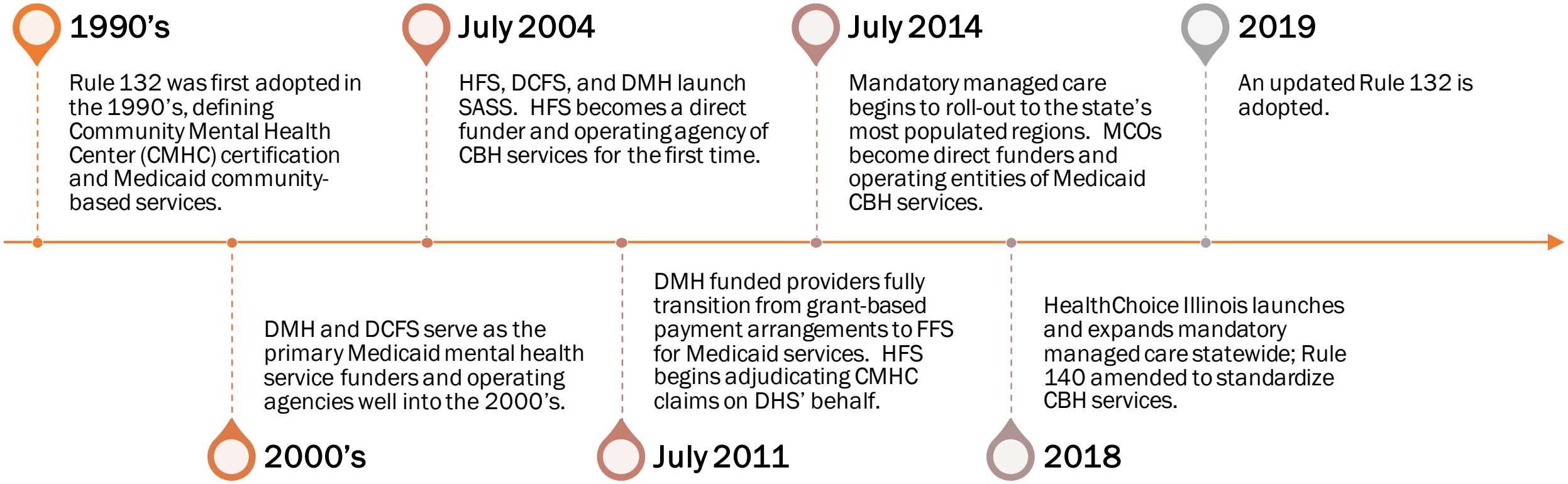
1. A **covered service**,
2. Provided to an **enrolled customer,**
3. By a **certified provider**.

If any one of these is missing on the date of service, Medicaid will not pay.

When we think about Medicaid compliance, we are often referring to some aspect related to one of these three fundamental components.



HISTORICAL PERSPECTIVE



RULE 140

- 89 Ill. Admin. Code 140
- Rule 140 is the broad administrative rule governing most aspects of the Illinois Medical Assistance Programs, including:
  - Who is eligible,
  - Who can provide services, and
  - What services are covered and how they will be paid (sound familiar?)
- Rule 140 covers more than CBH and sets the requirements (e.g. record requirements, audits, provider enrollment, payment of claims) that every provider must adhere to as condition of participation in the Medicaid program.
- Rule 140, Section 453 (140.453) is where CBH services are now defined.

SO, WHAT CHANGED?

- The amendments to Rule 132 and Rule 140 in 2018/2019 significantly changed the regulatory landscape for Medicaid community-based behavioral health.
- CMHC certification and CBH service definitions were split:
  - Rule 132 maintains the requirements and process for organizations to be certified as a CMHC.
  - Rule 140 (Section 453) maintains the CBH service definitions and staff qualifications.
- BHCs (140.499 and 140.Table O) introduced as a new Medicaid provider type qualified to deliver most CBH services.
- Certain Independent Practitioners (IPs) became eligible for reimbursement of a subset of CBH services.
- Program approvals for the delivery of certain CBH services introduced (140.Table N).

WHAT HAVE THESE CHANGES MEANT FOR PROVIDERS?

- Both Rule 132 and Rule 140 updates significantly streamlined requirements, reducing administrative overhead for providers.
  - CMHC certification requirements and processes streamlined.
  - CBH service definitions were streamlined and brought in line with the Medicaid State Plan.
- BHCs provide additional options for smaller organizations, satellite offices, and providers delivering a specialized set of services to participate in the Medicaid program, expanding access to services for more customers.
- Post-payment reviews (PPR) are no longer specifically defined for CMHCs above and beyond audit requirements for other Medicaid providers.

AUDITS

- 89 Ill. Adm. Code 140.30
- In the context of Medicaid, an audit refers to ensuring provider reimbursement was appropriate (Medicaid basics). Audits may occur as a result of standard program oversight or due to suspected fraud, waste, and abuse.
- May include pre or post payment reviews of services.
- The payer of services, HFS, and the federal government all have a right to audit Medicaid payments made to a provider.
- Things that are NOT a Medicaid audit:
  - CMHC/BHC certification reviews;
  - HFS Program Approvals;
  - Accreditation reviews;
  - Contract or program monitoring and compliance activities.

WHAT'S NEEDED FOR AN AUDIT?

- During an audit, a reviewer needs to be able to see sufficient documentation to reasonably conclude that services:
  - Were actually provided;
  - Were provided at the level billed;
  - Were delivered consistent with applicable policy; and,
  - Were medically necessary.
- It is the responsibility of the provider to maintain sufficient documentation to support payment for the services billed. This should include:
  - Personnel records for staff rendering services;
  - A signed service note (amount, duration, scope);
  - Completed copies of the customer's IATP or other medical necessity documentation consistent with HFS policy
- Any audit on a Medicaid funded service must be conducted in line with policies applicable to the service as defined and interpreted by HFS.

HFS RECORD REQUIREMENTS

- Record requirements, including documentation required for certain services, used to be defined in Rule 132.
- Documentation requirements for CBH services were streamlined in the updates to both Rule 132 and Rule 140.
- Record requirements for CBH services are now defined in HFS policy:
  - 89 Ill. Adm. Code 140.28
  - HFS Handbook for Providers of Medical Services, General Policies and Procedures (Chapter 100, Section 110)
  - Handbook for Providers of Community-Based Behavioral Services (CBS Handbook)

KEY PLAYERS AND THEIR ROLES WITHIN THE MEDICAID CBH SYSTEM

HFS	DHS-DMH	DCFS	MCOs
• IL Medicaid Authority • Administers and oversees Medical Assistance Programs, including MCOs • Maintains Rule 140, the CBS Handbook and fee schedule • Enrolls Medicaid providers via IMPACT • Certifies BHCs (OMI) • Conducts CBH service Program Approvals (OMI) • Funder of FFS CMHC claims for SASS, BHCs, and IPs • Adjudicates DMH-funded CMHC claims	• IL Mental Health Authority • Issues and administers the MH Block Grant and other grants to establish a continuum of mental health services in the state. • Maintains Rule 132 • Certifying body for CMHCs (BALC) • Funder of FFS CMHC services	• IL Child Welfare Authority • Establishes state-funded or IV-E funded contracts for additional MH services, child welfare supports, and residential treatment. • Directly funds FFS CMHC claims for DCFS-involved youth • Certifying body for CMHCs (IPI)	• Organizations contracted with HFS to administer the Medicaid benefit to enrollees • Establishes a Provider Network via contracts of enrolled Medicaid providers • Provide care coordination to high-risk and special population enrollees • Largest funder of Medicaid CBH services

RESOURCES

- HFS Provider Notices
- HFS Provider Handbooks
- IMPACT
- CBS Fee Schedule
- Rule 132
- Rule 140
- CBS Services FAQ

THANK YOU!

HFS.BHCOMPLIANCE@ILLINOIS.GOV